News: Trailblazer outlines inpatient vs observation status documentation pitfall

Following a targeted review of 250 claims with DRG 247, TrailBlazer, the Medicare Administrative Contractor (MAC) for Jurisdiction 4 (J4) which includes Colorado, New Mexico, Oklahoma, and Texas, denied 98.8% of the claims essentially due to documentation issues regarding billing outpatient services as observation rather than inpatient status.

Of the nearly 99% of claims it rejected, TrailBlazer says it denied 87% because the medical record did not support the inpatient level of care. Another 11% received denials due to incomplete or missing documentation, with the remaining 2% rejected due to non-coverage issues.

The crux of the problem, according to TrailBlazer's May 2009 notice, stems from the following concerns:

- Routine inpatient admission following a postoperative outpatient procedure for clinically stable patients
- Documentation did not support the medical necessity of an inpatient level of care
- Patients were admitted without documentation that clinical complications were present on admission.
- The care rendered was observation in most cases.

Providers should consult the CMS *Medicare Benefit Policy Manual,* available on the CMS Web site at http://www.cms.hhs.gov/Manuals/IOM/list.asp, for more information on admissions and official regulations to help avoid claims denials. In addition, TrailBlazer shared the following information regarding inpatient versus outpatient services:

- **Outpatient observation is still an alternative to inpatient admission**
- **An order simply documented as "admit" will be treated as an inpatient admission. A clearly worded order such as "inpatient admission" or "place patient in outpatient observation" will ensure appropriate patient care and prevent hospital billing errors.**
- **Medicare coverage for observation services is limited to no more than 48 hours unless the A/B MAC grants an exception.**
- **An outpatient observation patient may be progressed to inpatient status when it is determined the patient's condition requires an inpatient level of care.**
- **An inpatient admission cannot be converted to outpatient observation unless condition code 44 requirements are met. Documentation must support the level of care provided (inpatient admission versus outpatient observation).**

A final piece of advice from the Medicare contractor, of which CDI specialists should take note, includes the following: "**Ensure the documentation addresses problems identified in the history and physical, treatment initiated, patient's response to treatment, major changes in the patient's condition and action taken, status of unresolved problems, discharge planning and follow-up**."

Inpatient Admission Versus Outpatient Observation Following an Outpatient Procedure

(5/19/2009)

TrailBlazer, the A/B Medicare Administrative Contractor (MAC) for Jurisdiction 4 (J4), has recently reviewed a targeted sample of 250 claims submitted on Type of Bill (TOB) 11X with Diagnosis-Related Group (DRG) 247 during the period of January–September 2008. The purpose of this medical review was to evaluate services billed as part of the Inpatient Prospective Payment System (IPPS) Pilot. Medical Review Part A performed complex medical reviews and made determinations based on Medicare reimbursement requirements pursuant to the provisions of the Social Security Act Sections 1862 (a)(1), 1979 and 1870. The audit focused on:

- Verification of Medicare coverage for billed services.
- Determination of medical necessity.
- Determination of appropriateness of care setting.
- Appropriateness of procedure reviews (if applicable).
- Validation of the DRG.
- Determination of limitation on liability decisions.

The results are shared with the provider community in an effort to provide education, increase awareness, decrease billing errors and reduce vulnerabilities to the Medicare Trust Fund. An error rate of 98.8 percent was found in this review.

The Progressive Correction Action (PCA) error rate is calculated by the following formula:

$$\frac{\text{Dollar amount of services paid in error, as determined by Medical Review}}{\text{Dollar amount of services medically reviewed}}$$

Based on the results of the targeted review, the following problem areas were identified:

- Routine inpatient admission following a postoperative outpatient procedure for clinically stable patients. Documentation did not support the medical necessity of an inpatient level of care. Patients were admitted without documentation that clinical complications were present on admission. The care rendered was observation in most cases.
- Confusion on how to bill the outpatient service as observation instead of inpatient services.

Medical Review denied 98.8 percent of the claims reviewed in the sample. The reasons and percentages of denials are listed below:

Reason	Percentage of Denial
Medical record did not support inpatient level of care	87 percent
Incomplete or no documentation received	11 percent
Provider adjusted claim as non-covered charges	2 percent

The CMS *Medicare Benefit Policy Manual*, Chapter 1, “Inpatient Hospital Services Covered Under Part A” indicates the following:

“The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., **they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis.** However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history

and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting."

Providers may identify factors to be considered when making the decision to admit in the CMS Medicare Benefit Policy Manual available on the CMS Manuals Web page at:

http://www.cms.hhs.gov/Manuals/IOM/list.asp

TrailBlazer would like to reiterate the following information shared with the provider community regarding inpatient versus outpatient services:

- Outpatient observation is still an alternative to inpatient admission.
- An order simply documented as "admit" will be treated as an inpatient admission. A clearly worded order such as "inpatient admission" or "place patient in outpatient observation" will ensure appropriate patient care and prevent hospital billing errors.
- Medicare coverage for observation services is limited to no more than 48 hours unless the A/B MAC grants an exception.
- An outpatient observation patient may be progressed to inpatient status when it is determined the patient's condition requires an inpatient level of care.
- An inpatient admission cannot be converted to outpatient observation unless condition code 44 requirements are met. Documentation must support the level of care provided (inpatient admission versus outpatient observation).
- Ensure the documentation addresses problems identified in the history and physical, treatment initiated, patient's response to treatment, major changes in the patient's condition and action taken, status of unresolved problems, discharge planning and follow-up.

Please refer to the "Inpatient Admission Versus Outpatient Observation Following an Outpatient Procedure" job aid for additional guidance at:

http://www.trailblazerhealth.com/Publications/Job%20Aid/InptatientAdmissionvsOutpatientObservation.pdf

Providers can view other helpful resources to assist with billing inpatient admissions and observation services on the TrailBlazer Job Aids Web page under the Part A heading at:

http://www.trailblazerhealth.com/Publications/Job%20Aids/Default.aspx?DomainID=1